THE EXPERIENCE OF ‘ALIENATION’ IN CHILDREN

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Feelings or, perhaps more adequately termed, experiences of alienation—which word I choose as the nearest equivalent to the perhaps more striking German ‘Entfremdungsersrebnnis’—are extraordinarily rare in childhood. This type of disorder includes such phenomena as depersonalization, derealization, metamorphopsia and so on. They often present as obscure somatic disorders at first sight and are referred to the paediatrician or other ‘somatic’ consultant.

A series of five cases was published in 1958 (Salfield, 1958a). Meyer (1959), in his even more recent monograph on ‘Entfremdungsersrebnsse’, thinks that my first observation is one of a pubertal depersonalization. This is possible. It may also be so in the case of my second observation. He describes six pubertal, but no childhood cases. The literature which I reviewed shortly (Salfield, 1958a) is restricted to one observation by Kanner, which is also quite likely one of a pubertal case. This leaves three childhood cases which I described. Two have been described with therapeutic details elsewhere (Salfield, 1957a; Salfield, 1961). Cures were effected in the former case by the application of Schultz’ autogenic training (Schultz and Luthe, 1959; Schultz, 1960; Salfield, 1957–1958, 1957b, 1958b, 1960; Aboulker, Chertok and Sapir, 1959) and the other by our non-directive method of ‘Pictures and Stories’ (Salfield, 1961; Salfield and Greenland, 1953). Inquiry from experienced children’s psychiatrists, including a very senior professor of child psychiatry, yielded no further information on similar observations except in pubertal schizophrenics. The latter remarked in a private communication that he was ‘from now on going to look for this’.Binswanger (1948) reports a self-observation at the age of 11 to 13 years.

Even in the psychiatric literature on adult cases there are few good descriptions of these phenomena. This excludes self-observations under the influence of drugs such as LSD and ‘mescalin’. The reason is clearly to be sought in the fact that such uncanny and distressing phenomena are difficult to describe, as the right words are lacking; moreover, people are reluctant to enlarge on experiences they feel are so abnormal, as usually full insight into their ‘unreality’ is preserved. This reluctance is also present in children, and their verbal resources are usually still more restricted than those of adults.

Since my first paper (Salfield, 1958a), which contains the material of three cases of undoubted ‘alienation’ in childhood, I have made five further observations. One was a girl of about 9 years who, on one or two occasions, felt, within the syndrome of an anxiety state with hysterical features, that her right hand swelled up to huge size, to return to normal size within seconds. This phenomenon did not recur for several months during which she was under observation. The other was a girl of 12, not yet somatically pubertal, but approaching it, who had a peculiar, indescribable experience of the room and the entrance to the school buildings being distorted and odd. This occurred on two occasions, but could not be described by her more precisely. She presented the picture of an obsessional, rumina-

phobia: she feared that she might find her mother dead one day, with the allusion that it might be of her doing; she had thoughts, very distressing to her, that she wanted her mother to be dead. On account of her age, we shall, in order to obviate the criticism that she might have been pubertal, exclude also her case.

There is thus a series of at least seven children with experiences of ‘alienation’. While only one case (Salfield, 1961) could be studied sufficiently for convincing ‘dynamic’ interpretation, three of the presented cases were investigated sufficiently for a clinical description.

Case Reports

Case 1. Lynne, age 12 years and 1 month, was seen because for 10 months she had felt as if ‘everything was getting very big’.

The school report stated that she was of average intelligence, but was poor in arithmetic. She had no special abilities, but neither had she special difficulties.
She attended well, behaved normally, but it was remarked that she was rather self-assertive with other children, authoritative with younger ones and very protective towards her younger sisters, also attending at the same school. Her father had died two years ago. Her mother worked in the evenings to support the family of children, who were well fed, well clothed and well cared for.

The psychologist found her I.Q. (Revised Stanford-Binet Scale Form L) to be 106. There was little scatter. She found Lynne pleasant, but 'normally cautious. She kept her big coat on'. She was at ease during the test and liked it. She 'listened, attended, concentrated and obeyed instructions exactly and carefully. She made an effort with items well within her reach', but the psychologist queried whether she gave up rather easily when the tasks went somewhat beyond her ability. She noted no nervous symptoms.

Her mother, a pleasant, sensible, competent, and normally concerned woman, in her middle 30's, gave information willingly.

**Present Disorder.** Four to five months before onset Lynne 'started' dreaming. From this she woke up, unable to remember the contents of the dream, shaking and terrified, to slip into mother's bed. She said that in the dream things appeared to get bigger; then this began to persist also in the waking state. For example, when turning on the water tap, Lynne would suddenly let go of it 'as if it were red hot', because it felt as if it was getting 'right big'. In the classroom, objects suddenly began to get bigger. This experience would make her 'feel sick'. Until three months ago this occurred very often, at least daily. Later it came on 'occasionally', and then she became frightened.

**Family History.** No family history of mental or 'nervous' disease was elicited.

Father died two years ago, age 42, quite unexpectedly and suddenly of a heart attack. Lynne did not appear to be very affected by this.

Mother, now 37, works at night in a cinema. She has done so for 18 months. Since then, Lynne has had bad temper outbursts when mother is present. When she is absent Lynne is no trouble.

There is a family of four girls. The eldest, 14 years, 'more intelligent than Lynne', takes charge when mother is away. She is 'throwing her weight about a bit'. The second (this case) is 12 years of age. The third is a girl of 10, and the fourth, a girl of 3 years.

Their mother thinks the children 'fight' a good deal among each other, and she remarked on herself, rather deprecatingly, that when her husband died she used to have the 'ague' and 'go off', become 'unconscious', not knowing what she was doing.

**Personal History.** Ante- and peri-nataly mother and child were well and the birth was normal.

Lynne was breast fed only for two to three weeks, then 'I lost my milk', but she thrived on the bottle.

Lynne has always been quite well and healthy, eating and sleeping well, even now. At 4 years, she had her adenoids removed because of 'bad breathing' and nasal discharge. She was in hospital for three days, but not visited. She had an appendicectomy at 5 years, when she was in hospital for nine days where she was visited twice. But she fretted so much that she had to be given an early discharge. There were no other separations. She had measles and also chickenpox, this quite severely.

Her milestones were normal: she was walking at 15 months, and started talking before then. She was completely dry at night at 5 years, during the day at 2 years, and she achieved bowel control between 12 and 18 months.

But her mother described Lynne as 'always easily upset, always a highly-strung child with tempers'. When she was between 3 and 4 years, she would rush screaming into the house because she thought 'someone was after her', even if they had only looked at her. At about 5 years she often became aggressive and 'started hitting out' when she was chastised. At present she was 'very much better' and had ceased to complain about dreams.

On examination Lynne presented as a quite unremarkable girl. There were no outward abnormalities, anxiety, shyness or the reverse. She appeared quite self-possessed, made good contact, was willing to do any tasks which she performed in a matter-of-fact manner, and she was perfectly willing to talk about herself. No psychotic or other symptoms suggestive of any other severe disturbance, in particular no delusions, auditory, visual, olfactory or other hallucinations were admitted apart from the following experiences which she related without noticeable anxiety:

'It all started with a dream, which I dreamed often. I was going on a hill and something like a ball was rolling towards me. I put my hand out and the ball was getting bigger and bigger, bigger every time I put my hand on.' She used to wake up frightened and rush to her mother's bed. Then the bedclothes and other objects also got bigger and bigger. This feeling came on for the first time after the dream and quite often subsequently. When she looked at things for a while they became blurred, 'then I can't see what they are'; 'Don't know what they are, can't understand what they are and later can't tell what they are. They are queer. White, like on T.V. Lines on things all ways and waving and going in and out.' For instance, she looked at a photograph in an album. 'Looked at it when I was not very well. Couldn't understand what it was, once or twice with photos. They were pictures of Mum, Mum's brother, Mum's friends and babies, Grandmas'. This last information on what the pictures represented was given only after much urging. This blurring of pictures became worse; but it did not arise, when she had tonsillitis, after which these feelings occurred much more rarely. Independent of the acute infection she also felt her fingers getting bigger.

Some such sensations used to occur once or twice a day and lasted for 10 minutes.

A short neurological check did not reveal any abnormality. Her tonsils did not appear particularly suspect.
Further investigations included a Z-test (Table 1) (a shortened three-plate form of the Rorschach Inkblot test) and the Bene-Anthony Family Relations test (Bene and Anthony, 1957).

**Z-test Record.** The number of reactions is low average. Three are non-committal 'patterns'. There is marked suppression of M, FM and colour. The W responses are all 'easy'; there is little organization activity. There are, apart from too many inferior F, at least one F—, probably many more ± or even — responses. The only H response is a 'picture', not 'real' people. The variety of content is poor. The record is grossly constricted. The whole points to a constricted and perhaps somewhat depressed personality. But some of the responses might have been much more developed by the testee who obviously did not do herself justice. However, there is an adequate number and quality of P responses. Response no. 6 is of possible significance as an allusion to a suppressed sexual experience, an observation perhaps. This is the record of a withdrawing, inhibited child, possibly depressed, but not psychotic or grossly neurotic.

*The Family Relations Test* (Bene and Anthony, 1957). This consists of a variety of human shapes cut out of cardboard, without facial features, but suggesting persons of both sexes and a variety of ages, from baby to grandparents. These shapes are stuck on small boxes which have a slot, into which 'messages', written on small cards, are to be 'posted' according to whom the testee thinks these messages should be addressed. The testee chooses a number of these shapes. I asked Lynne to make up a family, like her own. Then I read the messages and Lynne 'posted' these. These messages are identifiable by the numbers they carry on their backs and they are also classified according as they signify overprotection, overindulgence and feelings. The latter are the most numerous and are grouped as outgoing and incoming, positive and negative, mild and strong, from the testee's point of view. A special feature is the figure of a person whose back only is seen. He is 'Nobody' and the messages that are not attributed by the testee to anybody can be 'posted' in Mr. Nobody. Also 'Self' figures in the 'family'. This is an entertaining 'game' and Lynne engaged in it wholeheartedly.

The theory of this 'game' is, like that of so many 'projective' or 'evocative' tests, doubtful and cannot be discussed here. But in my own experience with this test, reasonably accurate assessments of the testee's feelings towards the members of the family can be obtained and sometimes information otherwise completely missed or concealed.

One immensely important piece of information elicited was her feelings about her father. She picked a 'father' for her family, posted three messages to him, and then suddenly remembered that she no longer had a father. These messages were one negative mild outgoing and two negative strong incoming 'feelings'. Father is seen as 'bad'. These messages were: that he sometimes complains too much, punishes her too often and does not love her enough. She herself is too quick- and bad-tempered. Four out of eight negative strong outgoing responses were suppressed, i.e. posted to Mr. Nobody, as were five of eight incoming negative strong responses, i.e. a strong denial of hostility in general. Her feelings are directed towards, and come from, in the main, the baby sister; in other words, she adopts a maternal attitude towards her, but mother is not ousted, although of slightly lesser importance to her, i.e. an essentially adult attitude. The whole situation, as this child apprehends it, is one of premature independence with much expression of positive feelings but largely repressed negative feelings, probably on account of her own feeling of badness, the logic of it being somehow that father punished her by dying, therefore, it is dangerous to express hostility. Understanding this child's situation in this way, one may also understand the feelings of unreality as a result of inordinate attempts at coping with guilt, danger and insecurity by assuming an unbearable role of independence and maturity. This discrepancy between what she is and what she feels she ought to be in order to safeguard herself, gives her the feeling that the environment is becoming unnaturally large, overpowering and intimidating. Her hands, the organs with which one tackles the world and handles it, attempt to become proportionate to the task, but in vain. Her dream puts it clearly—she is in danger literally of being bowled over.

The symptoms receded gradually and she became more serene and, when seen last, about two months after the initial interview when the symptoms were already much less prominent than when she was at her worst, she was free from symptoms and appeared in all respects normal.

Our inquiry nine months later remained unanswered. The letter was returned, as the family had 'gone away'. I feel that, in view of the good relations that had been established, mother would have applied for further help had the child relapsed.

### Table I

<table>
<thead>
<tr>
<th>Plate</th>
<th>Reaction No</th>
<th>Content</th>
<th>Scoring</th>
</tr>
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<tbody>
<tr>
<td>I</td>
<td>1</td>
<td>A beetle</td>
<td>W'FAP</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>A crab</td>
<td>W'FAP</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>A pattern, wall-paper</td>
<td>W'pattern</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>A pattern, wall-paper</td>
<td>W'pattern</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Insects, worms and snails</td>
<td>DFC A</td>
</tr>
<tr>
<td>II</td>
<td>6</td>
<td>Two moles together, stood up, like making love</td>
<td>DFM AO</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Decorations, ornament</td>
<td>WF Object</td>
</tr>
<tr>
<td>III</td>
<td>8</td>
<td>People, two red and black ones, like shapes in a pattern, nursery rhyme pictures</td>
<td>W'-(FC) H</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Design for books, simple figures the outlines</td>
<td>W'F pattern</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>A butterfly</td>
<td>D FA P</td>
</tr>
</tbody>
</table>

W' = cut-off W, otherwise usual symbols. No significant reaction times. Total time normal, about eight minutes.
The 'interpretations' are cautious, and in most details the facts are allowed to speak for themselves.

Case 2. Brian, almost exactly 12 years of age, was referred to the paediatrician because he had had 'dizzy bouts' for two months, lasting about two hours each. During the attacks he felt as though his head was 'blocked up' and 'people are speaking differently'. At these times he had 'a foul temper'. He also had frequent headaches. He had no epileptic attacks, nor was there a family history of epilepsy. Mother reported that the boy 'keeps going queer', both at school and at home. Mother observed that he 'went white' during the attack on one occasion, and his eyes 'looked different'.

His own description was that the attacks were all the same, but varied in intensity. Everything goes 'a bit dark' and 'looks different'. The tone of people's voices seems to alter to a higher pitch. But he understands what they are saying. The attacks took place about once a week then; they used to occur at intervals of several weeks, and they lasted between five minutes to two hours.

He said he was getting on well at school. He did not complain of any more headaches. He sometimes gets 'a lump at the back of my throat', and he stammered. The attacks started three years ago, but he had been improving except for the last two months, since when his speech had deteriorated. He bit his nails.

In his personal history there were no diseases of importance except that four years ago he had had abdominal pains which were investigated; a tentative diagnosis of mesenteric adenitis or a sub-clinical attack of infective hepatitis was made on the strength of bilirubin but no increase of urobilin in the urine, and with a normal blood-count. The Mantoux test was negative.

The family history revealed nothing relevant. The physical examination was normal in every way, including routine laboratory examination. Heart test negative; the electroencephalogram was 'immature', with no evidence of epilepsy. A month later markedly aggressive behaviour was complained of by the parents and the boy was referred to me. He was seen 10 weeks after having been seen first by the paediatrician.

The history given by his mother previously was suitably amplified and revealed many features of psychiatric interest.

She reported that the boy was normally good tempered, but his bad temper arose when he was disciplined or made to do things at times. The number of attacks had increased to two to three per week, sometimes one daily, sometimes less often. The first attack happened just when he was getting off the bus to watch a Cup Final football match. It had been remarked by the paediatrician that the boy was very fond of 'Emergency Ward 10'. There may thus be a connexion between over-stimulation and excitement, although the attacks were said to occur at any time.

Mother also remarked on the occurrence of 'nasty dreams'. She told me that she and one of the boy's sisters were in good health, but one girl was easily frightened, e.g. of the dark. Father had been off work for over a year, with a prolapsed disk, but during that time had developed a condition when 'he cannot pass water'. But x-rays had no result'. Also he had a 'bad stomach'. He feels that air goes down his chest, and other bizarre feelings also occur. It can, therefore, be assumed that a somewhat 'neurotic' atmosphere reigns at home. This is also confirmed by later parental behaviour.

The boy amplified his description as follows: He almost always has a headache, when he has an 'attack'; the two start usually at the same time; and during an attack 'time goes slow; people talk louder and slower; everything feels different'. When this was queried, he said: 'Everything! I feel the change, but can't exactly tell.'

One of my psychologists gave him the Z Test (Table 2). She found the boy quiet and tense, but very co-operative, the impression I had gained myself.

The number of reactions is average. There is marked suppression of M and colour. He finds whole responses practically impossible to achieve, there is no organizational activity. When pressed hard, he sees 'people fighting', but not spontaneously. The many small details indicate an obsessional personality, but these five de responses remain at the periphery. He seems to be depressed, withdrawn from contact through fear of his own aggression or through suspiciousness. He is, at any rate, inhibited and emotionally restricted.

The similarity in emotional indicators to the previous record is quite striking.

I admitted him to our convalescent unit for observation and there he attended the hospital school. He was reported somewhat difficult to manage; but he said he liked it there, and expressed regret that he had not come before. He was there for 12 days, during seven days of which he had half a tablet of 'dexten' in the morning. He had one 'attack' during his stay, but not while he was on medication. He was discharged prematurely, against advice. Mother insisted on taking him home, as his father who had to enter hospital himself was, according to her, 'too worried not to see the boy'. No more was heard from the family and no reply was received to an inquiry made recently.
Case 3. Ruth, age 10, was referred by the ophthalmologist because she saw everything in different shades of green. Even black appeared to her as dark green. He could not discover any objective signs.

Present Disorder. About two months previously, while clearing tables at school, she happened to look at the clock. It looked green and appeared to be shaking. Then she noticed that the writing on the blackboard appeared green, then 'everything' looked green. The black of the board was green. A sideboard looked 'yellow-brown' with green patches on. How long this 'attack' lasted was difficult to establish. But it must have been at least several minutes. For a month, everything looked green, many times a day, for a few minutes, and further 'shaking' of objects also appeared occasionally in conjunction with it. Her account of the complaint varied in some details from time to time, but the essential fact of chloropsia and the 'shaking' of the clock and other objects, seemed well established. The phenomena disappeared gradually, and after a month she had returned to 'normal', so that she had been free from symptoms for about a month when I first saw her.

Family History. Father suffers from peptic ulcer, is a worrier and is easily upset.

Mother flares up easily. As a child she had 'liverish attacks' when things danced in front of her eyes and appeared to have white spots on them.

An elder brother is said to be well and normal.

Patient's identical twin was described as carefree, but she had 'tempers'.

Personal History. Birth was uneventful and normal, although two months premature. Patient was breast-fed for a short time, but thrived on the bottle.

Walking, talking and toilet training were all achieved within normal time limits.

There were no separations. She had only ordinary childish ailments; she started school at the ordinary time and is average. Sleep is good, bowels regular; she is a little faddy with her food. She likes gardening, needlework, ballet dancing, has friends and is sociable.

But her mother described her as 'a worrier' who always 'finds a snag'. On car journeys she 'hopes we won't crash'. When dancing on the stage she gets 'tummy trouble'. When anything unusual is impending 'she toddles all the while to urinate'. She has headaches at night; she massaged ointment into her feet for weeks because of 'pains'. 'Always full of aches and pains.' If her mother ignores this, she will 'still have something else'. She argues about everything and nothing and always contradicts. She tries to assert herself all the time. She is jealous of her twin and is 'a different child' when they are separated. There had never been convulsions or loss of consciousness.

On examination she appeared pleasant and unremarkable. No physical signs were discovered, and a neurological consultation did not reveal any abnormalities.

Further Investigations. On intelligence and school achievement tests she was average. At school she is no problem, although she had a short 'awkward' and 'uncooperative' period a few years ago. On the Ishihara test for colour blindness she confabulated a good deal and gave many 'approximate' answers, reading 3 as 8, 74 as 81, 97 as 87, 73 as 78; 29 she read as 19 and, when asked to look again, as 20. These mis-readings had no relation to the colour qualities of the charts.

The electroencephalogram showed a marked excess of slow activity at 4-7 c/s, generally diffuse and random, but occasionally more marked in the left posterior temporal leads, with instability on overbreathing, the clinical significance of this being unclear.

She produced, on request, drawings of a man and a woman. When drawing the man she said: ‘The dark outline looked green while I was doing it—then it went away again.’ The drawing of a woman is, however, so bizarre that it throws a grave suspicion on the quality of her relations with her mother (Fig. 1).

The general impression was that of a child with a great deal of suppressed aggression. She seemed to be in fierce competition with her twin, and to have a strongly ambivalent relation with her mother. Her personality
make-up is no doubt of the hysterical type. Unfortunately, her mother felt that 'a lot of fuss' was made and, in view of her reluctance to co-operate (on her second visit she seemed to regret that she had disclosed 'too much') and as the child remained free from the symptoms she had been originally referred for, there was no choice but to discharge her, while leaving the door open to future consultation.

Conclusions

In contrast to common belief, experiences of 'alienation' can be observed in children. Though they are not frequent, they may occur in an estimated frequency of one in 200 child psychiatric patients. They often present as obscure somatic disorders. In adults, depersonalization and similar symptoms are usually fairly persistent, lasting perhaps one to two years or more, and tend to recur. In children they often seem to be more fleeting, although the trouble may occasionally be persistent. Relapses have not been encountered as yet. Treatment in adults is usually unpromising, but in children it is, in our experience, either not required for the symptoms as such, or else definitely promising. Psychotherapy, auto-hypnotic relaxation (autogenic training) and dexamphetamine have, in our experience, been useful, although the number of cases in which treatment had to be given is small. The amines have, according to Meyer (1959) the 'relatively best therapeutic effect' in the comparable disorders of adults. Our observations in children showed definite psychopathology which appeared to be causally connected with the 'alienation' experiences.

References


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